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Client's name:_____ Date: ___/___/_____

Gender: _____ F_____ M Date of birth:_____/_____/_____ Age:_____

Form completed by (if someone other than client): _____

_____

Address:_____ City:_____

State:_____ Zip:_____

Phone (home):_____ Phone (other):_____

Emergency contact name: _____

Phone: _____

Highest Level of Education:_____

Current Profession:_____Current Employer: _____

Primary reason(s) for seeking services: _____

_____

_____

Marital Status (more than one answer may apply): _____Single

_____Divorce in process _Unmarried, living together _____Legally married

_____Separated _____Divorced _____Widowed _____Annulment

Total number of marriages: _____

Assessment of current relationship (if applicable): □ Good □ Fair □ Poor

Who is living at current residence? (please list names and ages):_____

_____

Children not living in the home? (please list names and ages): _____

_____

Family Mental Health History: Has anyone in your family including yourself experienced difficulties with the following? (check any that apply and list family member, e.g., Sibling, Parent, Uncle, Self, etc.):

Depression: □ No □ Yes _____

Bipolar Disorder: □ No □ Yes _____

Anxiety Disorders: □ No □ Yes _____

Panic Attacks: □ No □ Yes _ _____

Schizophrenia: □ No □ Yes _____

Alcohol/Substance Abuse: □ No □ Yes _____

Eating Disorders: □ No □ Yes _____

Learning Disabilities: □ No □ Yes _____

Trauma History: □ No □ Yes _____

Suicide Attempts: □ No □ Yes _____

Please describe previous experience with counseling including what was helpful and what was not helpful: _____

_____

_____

Substance Use: Do you currently use or have you used the following substances. If yes please describe frequency, amount, time of first use, and any current use (within the last 30 days):

Cigarettes: □ No □ Yes _____

Caffeine: □ No □ Yes _____

Alcohol: □ No □ Yes _____

Street Drugs: □ No □ Yes _____

Prescription Medication (not as prescribed by physician): □ No □ Yes _____

_____

Other: _____

_____

Medical/Physical Health (please check all that apply and provide further explanation in the space provided if necessary:

□ Dizziness/Fainting _____

□ Epilepsy _____

□ Sexually transmitted diseases _____

□ Allergies _____

□ Eating problems _____

□ Sleeping problems _____

□ Anemia _____

□ Fatigue _____

□ Hearing problems _____

□ Heart Problems _____

□ Vision Problems _____

□ Autoimmune Disease _____

□ Digestive Issues _____

□ Neurological Issues _____

□ Reproductive Issues _____

□ Other _____

Current Medications (please list both prescription and over the counter medication as well as dose, frequency, and reason for medication):

_____

_____

_____

Please list and medical, mental health, or other professionals I should speak with in order to provide you with comprehensive services: _____

_____

Development: Are there special, unusual, or traumatic circumstances that affected your development? □ Yes □ No If Yes, please describe: _____

_____

_____

_____

Has there been history of child abuse? □ Yes □ No If Yes, please share as much as you are comfortable sharing in the space provided: _____

_____

_____

_____

Describe Current Social Relationships: _____

_____

_____

_____

Describe Current Social and Leisure Activities Including Frequency: _____

_____

_____

_____

Spiritual/Religious: How important to you are spiritual matters?

□ Not at All □ Somewhat □ Moderate □ Very Much

Are you affiliated with a spiritual or religious group? □ Yes □ No If Yes, describe: ____

_____

_____

Military experience?: □ Yes □ No If Yes, describe: _____

_____

_____